



Outpatient Services • Clinics and Hospitals

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Transurethral Needle Ablation Benefit Added

Effective for dates of service on or after June 1, 2005, Transurethral Needle Ablation (TUNA), for the treatment of Benign Prostatic Hypertrophy (BPH), is a Medi-Cal benefit when billed with CPT-4 code 53852 (transurethral destruction of prostate tissue; by radiofrequency thermotherapy) and modifier -ZK.

The disposable cartridge, which is required to perform the procedure, is reimbursable when billed with code 53852 and modifier -22. The cartridges will be reimbursed at the lesser of \$1,000 or the invoice price. An invoice for the cartridge must accompany the claim or the claim will be denied.

Prior Authorization

Prior authorization is required when billing code 53852 with modifier -ZK or modifier -22. When requesting authorization, providers must include both the procedure and the cartridge on the same *Treatment Authorization Request* (TAR) using separate service lines. The TAR will be approved only when both the procedure and the cartridge are requested at the same time. Providers must document all of the following:

- The trial and failure of medical treatment for the urinary flow obstruction, or contraindication for medical treatment
- The work-up, including:
 - Urinalysis
 - Measurement of prostate specific antigen (PSA)
 - Simple uroflowmetry
 - Transrectal ultrasound
 - Cystoscopy
- A diagnosis of hyperplasia of the prostate (ICD-9 codes 600.0 – 600.9)

This information is reflected on manual replacement pages surg urin 5 (Part 2) and tar and non cd5 3 (Part 2).

Continued Serostim® Therapy Correction

The criteria for approving Serostim® in the treatment of Human Immunodeficiency Virus (HIV)-associated wasting was incorrectly stated in the June 2003 *Medi-Cal Update*. The correct policy should read: Therapy beyond 12 weeks may be continued with a recipient who has demonstrated a beneficial response to Serostim® during the initial 12 weeks of therapy (defined as a 2 percent or greater increase in body weight or Body Cell Mass [BCM]).

The incorrect policy indicated therapy could continue if a 2 percent or greater increase in body weight or BMI occurred.

The updated information is reflected on manual replacement page inject 51 (Part 2).

Children's Treatment Program Eligibility and Claim Submission Updates

Effective for dates of service on or after May 1, 2005, providers must verify eligibility of Children's Treatment Program (CTP) recipients with each visit. The recipient must have a Benefits Identification Card (BIC). For Immediate Need or Minor Consent Program recipients, a paper Medi-Cal ID card is acceptable. The *Confidential Screening/Billing Report* (PM 160) is not acceptable documentation for eligibility verification purposes.

Claim Submission Reminders

Providers are reminded that Medi-Cal claim forms submitted for services rendered to CTP recipients must include a valid recipient identification number, and a PM 160 form must be attached. Acceptable IDs are BICs, Client Identification Numbers or Social Security Numbers.

Updates being made to the claims processing system may have delayed adjudication of some CTP claims. Providers will be notified on a case-by-case basis whether claim submission deadlines will be waived for any of their claims. Full reimbursement will be paid for claims affected by such delays.

To qualify for CTP services, recipients must be younger than 19 years of age on the date of service, meet eligibility requirements for the Child Health and Disability Prevention (CHDP) program and not be covered by private health insurance, Medi-Cal without Share of Cost, California Children's Services or any other publicly funded program.

-QW Modifier for Laboratory Procedures

Effective for dates of service on or after June 1, 2005, providers who possess a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or Certificate of Provider-Performed Microscopy Procedures (PPMP) are required to comply with the Centers for Medicare & Medicaid Services (CMS) requirements when billing for clinical laboratory tests or examinations classified as waived. Specifically, providers who possess a CLIA Certificate of Waiver or CLIA Certificate of PPMP must utilize a test kit and bill the program utilizing a -QW modifier with the following CPT-4 codes for clinical laboratory tests or examinations:

80061, 80101, 81003, 81007, 82010, 82044, 82055, 82120, 82273, 82274, 82465, 82523, 82570, 82679, 82947, 82950, 82951, 82952, 82985, 83001, 83002, 83036, 83518, 83605, 83718, 83986, 84460, 84478, 84703, 85014, 85018, 85610, 86294, 86308, 86318, 86618, 86701, 87077, 87210, 87449, 87804 and 87880

By utilizing the -QW modifier, providers are certifying that a kit was utilized for performance of the clinical laboratory test or examination. Please refer to the CMS Web site at <http://www.cms.hhs.gov/clia/waivetbl.pdf> for a listing of manufacturers whose test kits have been approved for use with the -QW modifier.

Providers who possess a CLIA Certificate of Accreditation or CLIA Certificate of Compliance are not required to utilize a test kit when performing these clinical laboratory tests or examinations and should only bill with a -QW modifier when a test kit is used. In those instances when a test kit is not utilized, the provider must be certified in the appropriate proficiency testing specialty or sub-specialty.

Note: A -QW modifier is not required for CPT-4 codes 81002, 81025, 82270, 82962, 83026, 84830, 85013 and 85651 in order for the test to be classified as waived.

CPT-4 code 89300 is identified as a waived test by CMS; however, that procedure is not a benefit of the Medi-Cal program.

For more information about laboratory procedure code proficiency testing or waived tests, refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section in the Part 2 manual.

This information is reflected on manual replacement pages [path bil 2, 5 and 6](#) (Part 2).

Percutaneous Lysis of Epidural Adhesions Reimbursement Rate Update

Effective for dates of service on or after June 1, 2005, the reimbursement rate for CPT-4 code 62264 (percutaneous lysis of epidural adhesions, multiple adhesiolysis sessions; one day) changed to \$190.99.

Expanded Coverage for Irinotecan in Cervical Cancer Treatments

Effective for dates of service on or after June 1, 2005, claims for irinotecan (HCPCS code X7636) are reimbursable when billed in conjunction with ICD-9 diagnosis codes 180.0 – 180.9 (malignant neoplasm of cervix uteri). *This information is reflected on manual replacement page chemo 14 (Part 2).*

Recombinant Human Erythropoietin Policy Update

Effective for dates of service on or after June 1, 2005, only Epogen (HCPCS code X6836) may be reimbursed for the treatment of End Stage Renal Disease (ESRD) with dialysis, and only Procrit (HCPCS code X7030) may be reimbursed for Chronic Renal Failure (CRF) (pre-ESRD, non-dialysis) when billed for anemia secondary to CRF. Additionally, documentation showing hematocrit (Hct) and/or hemoglobin (Hgb) levels may be for the previous or current month. *This updated information is reflected on manual replacement pages inject 13 and 14 (Part 2), and on the Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements form.*

Cataract Surgery TAR Submission Update

Effective for dates of service on or after June 1, 2005, providers may submit *Treatment Authorization Requests* (TARs) with modifiers -52 (reduced services) and/or -54 (surgical care only) in conjunction with cataract surgery procedures with the following CPT-4 codes: 66800 – 66802, 66820 – 66821, 66830, 66840, 66850, 66915, 66920, 66930, 66940 and 66983 – 66985.

Modifiers -52 and -54 require “By Report” documentation. Claims for any of the above cataract surgery procedures submitted with modifier -52 or -54, but without “By Report” documentation, will be denied. *This information is reflected on manual replacement page modif app 1 (Part 2).*

Cancer Detection Programs: Every Woman Counts Poverty Level Income Guidelines

The 2005 federal poverty level income guidelines are effective April 1, 2005 through March 31, 2006. The guidelines are used to determine financial eligibility for applicants of Cancer Detection Programs: Every Woman Counts. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart. For additional Cancer Detection Programs: Every Woman Counts information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES

200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	\$ 1,595	\$ 19,140
2	\$ 2,139	\$ 25,660
3	\$ 2,682	\$ 32,180
4	\$ 3,225	\$ 38,700
5	\$ 3,769	\$ 45,220
6	\$ 4,312	\$ 51,740
7	\$ 4,855	\$ 58,260
8	\$ 5,399	\$ 64,780
For each additional person, add	\$ 544	\$ 6,520

This information is reflected on manual replacement page can detect 7 (Part 2).



Resubmitting Claims for HCPCS Code Z7610

In June 2004, the claims adjudication system incorrectly denied some claims submitted with HCPCS code Z7610 (miscellaneous drugs and supplies for non-surgical procedures). Affected claims were identified on the *Remittance Advice Details* with RAD code **9516: The secondary diagnosis code is missing or invalid for the procedure code**. EDS will reprocess the affected claims to be paid, or to be denied for a valid reason if a different error is found.

For providers wishing to receive payment earlier, special provisions have been made in the claims processing system for Z7610 claims to be exempted for timeliness, retroactive to dates of service on or after March 1, 2004. Providers may begin billing on May 1, 2005, or wait for the automated reprocessing of the claims by EDS. If a claim denies for a different reason, the claim may be resubmitted by means of a *Claims Inquiry Form* (CIF), as appropriate.

For CIF completion instructions, providers may refer to the *CIF Completion* and *CIF Special Billing Instructions* sections in the appropriate Part 2 manual, or on the Medi-Cal Web site at www.medi-cal.ca.gov. For more information about Family PACT, please call the Telephone Service Center (TSC) at 1-800-541-5555.



Provider Orientation and Update Session

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The next orientation session is scheduled for June 14, 2005.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Session below

June 14, 2005
The Hilton Oakland Airport
 1 Hegenberger Road
 Oakland, CA 94621
For directions, call
 (510) 635-5000

Registration

Call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session listed in this article. Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Please see Family PACT, page 5

Family PACT (*continued*)**Check-in**

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present their:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Certificate of Attendance

Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers will not receive a certificate.

Contact Information

For more information regarding the Family PACT Program, please call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at www.familypact.org.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

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Remove and replace: can detect 7/8
 chemo 13/14
 inject 13/14, 51/52

Remove and
replace at end of the
Injections section: *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form

Remove and replace: medne 5/6 *
 modif app 1/2
 path bil 1/2

Remove: path bil 5/6
Insert: path bil 5 thru 8 (*new*)

Insert at the end of
the *Surgery: Urinary*
System section: surg urin 5 (*new*)

Remove and replace: tar and non cd5 3/4

* Pages updated due to ongoing provider manual revisions.